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ABSTRACT

This paper describes the use of both quantitative and qualitative methods to evaluate a project designed to define a state system of care for meeting the needs of people with concurrent disorders of mental illness and substance abuse. The evaluation was intended to develop a feedback system to provide program implementers with information about the mechanics and processes of the project's panel and to monitor the changing level of trust and cohesiveness among panel participants. A further goal of the evaluation was to illustrate and elucidate the key issues impeding and facilitating the adoption of best practices in treating the population of interest. Data collection strategies included participant observation, telephone interviews, document analysis, and meeting evaluation forms completed by participants at each session. From these sources, 17 themes related to the panel process emerged. Data from the qualitative interviews produced a richer and more contextual perspective from which to evaluate the degree and quality of consensus among the panel participants. Combining quantitative and qualitative approaches allowed for triangulation and complementarity in the evaluation process. (SLD)

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The Utilization of Mixed Methods to Study Consensus Building in Dual Diagnosis Treatment

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The utilization of mixed methods to study consensus building in dual diagnosis treatment

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Background & Context

There is a growing awareness of the rates of co-occurrence of substance abuse among persons with severe mental disorders such as schizophrenia. Commonly accepted prevalence rates estimates the lifetime rates of substance abuse among persons with serious mental illness to be between 40% and 60% (Drake, Mercer-McFadden, Mueser, McHugo, & Bond, 1998). A number of issues have been identified that impede access to effective services for individuals experiencing co-disorders (Ridgley, Goldman, & Willenbring, 1990). These include separate funding streams for mental health and substance abuse treatment services, different theoretical-practice orientations (abstinence versus harm reduction), and different staffing models (peer staff traditions in substance abuse treatment versus credentialed staff in mental health treatment). Additionally, the growing transformation of community mental health services into managed care creates implications and barriers to effective integrated services.

Due to funding from the Substance Abuse and Mental Health Services Administration (SAMHSA), the Arizona Department of Health Services initiated a one-year consensus building project to define a state system of care for meeting the needs of persons with co-occurring disorders of mental illness and substance abuse. A thirty-five member cross-sectional panel was drawn from Phoenix and Tucson, the two largest urban populations in Arizona. This panel included representatives from state agencies, local regional behavioral health authorities, residential treatment providers, advocacy organizations, and case management agencies. Individuals included consumers, case managers, program managers, psychiatrists, advocates, and family members. The panel met on a monthly basis, and supported by a meeting facilitator, engaged in a 9-step strategic planning process. Additionally, the panel participated in periodic "knowledge exchange" sessions at which nationally prominent experts in the field of dual diagnosis treatment presented to the panel participants and typically followed with less formal exchanges, dialogues and discussions.

Evaluation Design

A combination of quantitative and qualitative methods were employed to evaluate this project. Our evaluation design was developed to address three key interests of the project team. First, we wanted to develop a feedback system that would provide the program implementers, most notably, the meeting facilitator, with information regarding the mechanics and processes of the group, including meeting effectiveness, representation and participation, and decision-making within the group. Second, we wanted to monitor

the changing level of cohesion and trust among the panel participants and to study these changes relative to the activities and issues being addressed by the panel. Finally, we wanted to illustrate and better understand the key issues impeding and facilitating the adoption of best practices in treating the population of interest.

Data Collection Strategies

- Participant Observation. Either the first or second author was in attendance at each of the panel meetings. The evaluators' presence at the meetings was explained at the first series of meetings and participants came to accept our presence and lack of involvement in the proceedings of the meetings. Informal networking and conversation would ensue between the evaluators and the panel participants during breaks and at lunch. These informal discussions and ongoing observation of the group afforded insight to understanding the dynamics of the group and the nature and quality of the participation and affiliation among and between the panel participants.

- Telephone Interviews. Interviews with panel participants were conducted by phone (two were conducted in person) over a period of 8 months. These interviews were conducted the second author, who also attended a majority of the panel meetings. The data from these interviews were confidential, accessible only to the two evaluators and the group facilitator. The interviews generally took between half an hour and an hour, sometimes more or less depending upon the stakeholders' available time. No formal questionnaire was developed for the individual stakeholder interviews. Rather, a checklist of general questions was gone over during each interview and stakeholders were encouraged to interpret this checklist in ways they thought were most appropriate. Subjects on the checklist included:
    - Stakeholder qualifications and histories of experience with dually diagnosed populations
    - Current services in Arizona
    - Consensus
    - Panel's progress
    - Panel representation
    - Implementation concerns
    - Recommendations for future monthly meetings

- Document Analysis. All key documents developed by the Consensus Panel were reviewed by the first and second author to identify recurrent themes, primary foci, panel principles and values, and outcomes of the group. These documents included the following:
    - ✓ Groundrules: adopted by the panel early in the meeting schedule and delineated the manner in which the panel meetings would operate and consensus would be defined.

- ✓ Principles: adopted by the panel approximately mid three-quarters through the meeting schedule that articulates principles that the Panel endorsed as guiding best practice in treating persons with dial disorders.

- ✓ Goals and Objectives: adopted by the panel and defining the outcomes, products, timelines and responsibilities that the panel would follow in carrying out their activities.

- ✓ Outcomes: adopted by the panel and delineating anticipated/desired outcomes for programs/systems and individuals that result from integrated treatment which the Panel endorsed as the goals of integrated services implementation in Arizona.

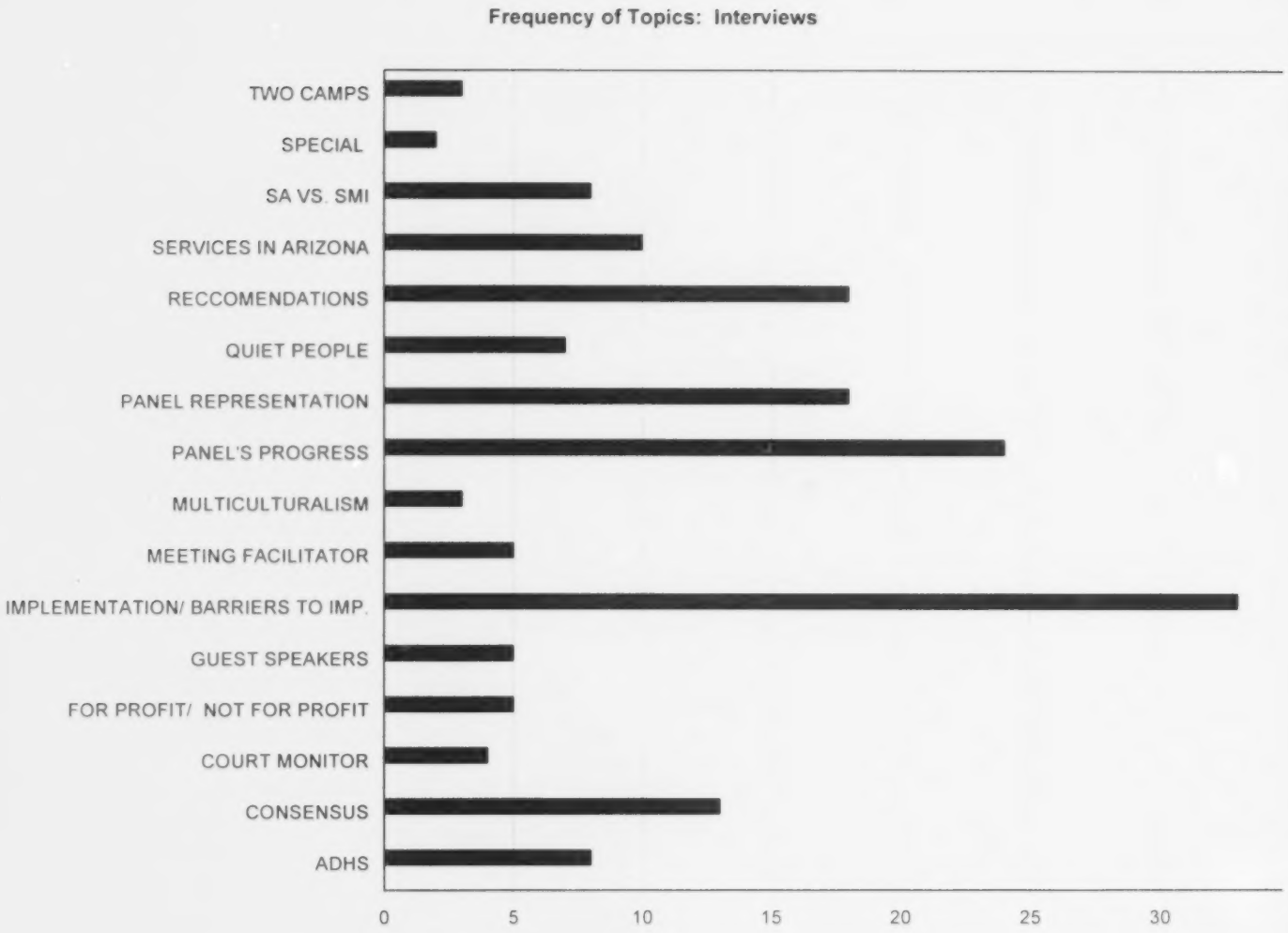
- ✓ Sub-Committee Reports: in implementing the workplan that they developed, the panel divided into three sub-committees or work groups. These included: funding, policies/procedures, and staff development/training. All reports, proposals, and correspondence of the sub-committee were reviewed for recurrent themes and cross-committee issues.

- Meeting Evaluation Forms. A 23-item questionnaire was distributed and collected at the conclusion of each meeting. These items used a 5-point Likert scale (anchored at Strongly Disagree/Strongly Agree) to solicit participants' responses to a series of statements assessing four constructs:
    - Group Cohesion
    - Participation
    - Meeting Effectiveness
    - Group Consensus

  Additionally, the questionnaire contained open-ended questions soliciting feedback about what the participants liked best about the meeting, liked least about the meeting, and recommendations for future meetings. Simple univariate summary reports of each meetings' completed evaluation forms were forwarded to the meeting facilitator as an ongoing formative feedback loop.

Results & Findings

Near completion of the one year consensus building period, qualitative interviews have been conducted with nearly all of the panel participants. Following these interviews, the write-ups for each interview were compiled in chronological date order into one document. Manual coding from this document ensued, using topic cards with subjects derived from frequency of responses. From the small set of subjects on the interview checklist, a total of 17 specific themes emerged. The following histogram displays the relative frequency of these topics.



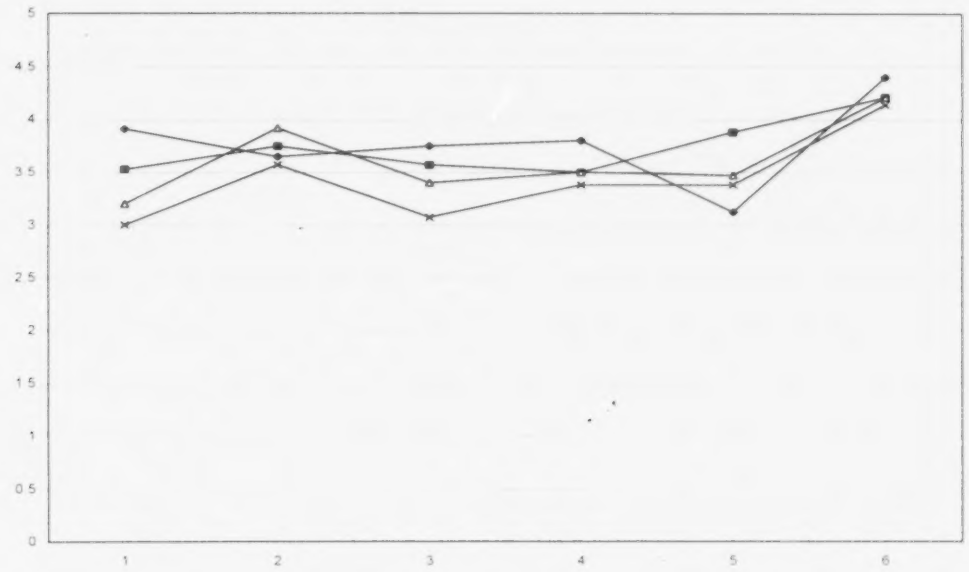
Following is a review of two of these themes: *Consensus* and *Panel's Progress*. These two themes were selected for illustrative purposes only for demonstrating the integration of qualitative and quantitative data. These themes have been selected for review because they perhaps best indicate the range of ideas, perceptions, hopes and concerns about the panel process, it's subject matter and it's possible outcomes.

Consensus

Four items from our meeting evaluation questionnaire attempted to assess participants' perceptions regarding the degree of consensus that had been achieved by the group. These four items read as follows and were rated individually on a five-point Likert scale:

- ✓ The group used effective decision making techniques

- ✓ At today's meeting, there was agreement among the group about what are the major barriers
- ✓ At today's meeting, there was agreement among the group about what an improved method of serving this population should be
- ✓ At today's meeting, there was agreement among the group what action needs to be taken to implement an improved system of serving this population.



As these data reveal, responses to all four statements were in general agreement, suggesting good consensus and effective decision making. All four items showed improvements over time, as the group continued to meet and as it began to move from more conceptual activities to more concrete actions.

Data collected from our qualitative interviews, however, provided a much richer and contextual perspective from which to evaluate the degree and quality of consensus among the panel participants. At the beginning of the panel, the stakeholders decided that the idea of "consensus" as it related to the integrated treatment panel was not going to refer to a strident concept of unanimous, absolute agreement. As the group's facilitator puts it, "it meant that either you agree with something or you can live with it." In spite of this early agreement, however, panel members did express some concern about the definition of consensus, and about whether or not consensus was truly being reached. For example, the sole panel member representing the "front line" of case management, expressed her concern that issues were being resolved too quickly, or that they were really not being resolved at all. According to this participant, it was this faulty way of deciding things which resulted in the determination that a particular Hispanic professional was brought onto the panel. She said that there were other, equally interesting candidates for the slot,

but all it took was the agreement of a few individuals on the panel and the case was closed. This issue of voting was also of concern to a program manager:

> *It (the panel) doesn't vote on anything. The only thing we voted on was who was going to be on the panel and we embarrassed ourselves doing that. When one person disagrees, we drop it and go on to something else. We at least need to have clarity and have a straw vote before we let it go. The way it is now is that if we're sick of it we move on.*

Several other panel members expressed concerns over the fact that, regularly, certain panel members remained quiet throughout the meetings, expressing neither agreement or disagreement. A psychiatrist summed up the concern:

> *Should Silence be taken as consent? Or is it something else? It really doesn't matter. The question is – when should we have a vote?*

In one outstanding instance, there emerged a difference of opinion on two counts. The first was in regards to the full definition of "SMI", related to what range of persons with mental health conditions would ultimately be able to receive services; the second was in regards to whether or not consensus had been reached on what that definition was. One particular panel member never felt satisfied with the definition and had the impression that the panel would return to the issue and work it out. By all other accounts, a consensus had been reached on the definition and the other panel members had no intention of ever going back to it. Repeatedly, this miscommunication reared its head in the monthly meetings, sometimes creating a sense of exasperation and hostility.

Panel's Progress

No items from the Meeting Questionnaire assessed the issue of the progress of the panel, although one statement asked participants to respond to the statement, "The group accomplished what is set out to do". Average scores for this item ranged from 3.87 (SD=.69) at the initial meeting, to 4.47 (SD=.64) at the most recent meeting. However, telephone interviews provided a more graphic and realistic perspective on the panelist's views and concerns about the panel's progress. Ideas about the progress of the panel, put in terms of the ability of the panel to meet its deadlines, varied more than any other theme. Initially, stakeholders were optimistic, with some expressing feelings of pleasant surprise, over the forward movements of the panel during the first several meetings. Many stakeholders were also panel members of a similar panel and these other affiliations provided a basis from which to compare. Early criticisms of the panel by stakeholders generally related to what were seen as unnecessary time allotted to getting grammar and wording of sentences just right. Certain stakeholders suspected that this time was spent in lieu of more important work and this came through in the interviews in spite of generally favorable reviews of the panel's progress:

> *There is too much attention paid to that wordsmithing crap. Paring down is not our job. The funders will do that anyways. But it is easier for people to do this than to deal with what really needs to be done.*

By July, concern about the panel's progress shifted. Panel members began expressing serious concern about the fact that time was marching on and the core principles had not been completed.

> *We have a lot to do and it's very hard to work in these subgroups between the meetings. We've gotten bogged down and I'm not 100% sure where we are. If Linda or someone could map things out for us at the next meeting that would be very helpful. But people are all pretty strapped for time. It would be nice for the group if it could keep meeting – after the panel ends – to help keep things on track.*

The concern over the timeline was also shared by the group's facilitator:

> *We needed to have started the subcommittee work earlier, what they are doing now could have been done a couple of months ago. Having said this, I believe that the time spent so far has been very valuable. But the group has only 4 meetings left and that's not a lot of time and I'm not comfortable with everything we need to do in that time. I wouldn't want to take away for the education aspect of the panel, but we have a lot to do. This is different from the TOPPS panel because on that panel the tasks are very specific. This is much more developmental. I hope that people will know that this kind of change doesn't happen overnight. The plan is for the system to come together over time.*

Key Implications

In summary, we utilized a mixed methods approach to conduct a formative evaluation of an initiative to develop consensus regarding treatment services to persons with mental illnesses and co—occurring substance abuse disorders. In this presentation, very preliminary findings and a limited amount of the data that have been collected and analyzed were presented to highlight the integration of qualitative and quantitative methodologies. By combining both approaches, our evaluation of this process was enriched and allowed for at two of the five purposes that Greene, Caracelli, & Graham (1989) lay out for mixed method evaluation designs. The examples provided above illustrate both the purpose of *triangulation* and *complementarity*. Three key implications of this evaluation warrant discussion:

- ✓ Linking evaluative feedback to group facilitation processes: in this project, we established feedback loops to the meeting facilitator about the information we collecting through our interviews and meeting questionnaires. This proved to be an invaluable source of rich information that allowed the facilitator to

adjust her style and group process to respond to the concerns, criticisms, and recommendations from the panel members that were not articulated within the larger group setting.

- ✓ Issues and challenges of representation: one of the greatest challenges of this type of collaborative process, is ensuring adequate and appropriate representation. In this initiative, persons of color and persons with mental illness and substance abuse disorders were not well represented, and for the most part, those that were invited to participate, attended a meeting or two and then dropped out. As such, greater attention needs to be paid to ensure the participation of a representative constituent.

- ✓ Continuing Efforts of the Panel: the panel continues to meet on a monthly basis and has organized itself into three sub-committee: funding; policies and procedures; and staff development and competencies. In December of this year, the panel will make a formal presentation to leading state agency heads.

References

Drake, R.E., Mercer-McFadden, C., Mueser, K.T., McHugo, G.J., & Bond, G.R. (1989). Review of integrated mental health and substance abuse treatment for patients with dual disorders. *Schizophrenia Bulletin, 24*(4), 589-608.

Greene, J.C., Caracelli, V.J., & Graham, W.F. (1989). Toward a conceptual framework for mixed-method evaluation designs. *Education Evaluation and Policy Analysis, 11*(3), 255-274.

Ridgley, M.S.; Goldman, H.H.; & Willenbring, M. (1990). Barriers to the care of persons with dual disorders. *Schizophrenia Bulletin, 16*(1), 123-132.